Board Determination of Mental Illness

1. Overview of Mental Illness

The first determination a mental health board must make is whether a person is mentally ill, alcoholic, or drug abusing. In the scope of the commitment process, "mentally ill" is considered to include alcoholics and drug abusers. Mental illness is not defined in the Act. A psychiatrist, a licensed clinical psychologist or a APRN is allowed by law to diagnose mental illness and will present an evaluation of the person appearing before the board. By statute a licensed alcohol and drug abuse counselor (LADAC) can diagnose substance dependency and other substance abuse issues. If board members have questions about the reported diagnosis, symptoms, or behaviors of a person appearing before them, it is important to question the mental health professional or LADAC and to receive answers.

Clinicians use the latest edition of DSM, the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association as the standard for diagnostic criteria in determining mental illness. There are five Axis categories in a diagnosis:

Axis I -- Mental Illness, and or substance abuse or ..dependence

Axis II -- Personality disorders, mental retardation

Axis III -- Physical conditions and disorders

Axis IV -- Psycho-social and environmental problems, stresses (housing, support group, occupation, education, social, legal system problems, accessing health care)

Axis V -- GAF (Global Assessment of Functioning; the rate of current overall occupational, psychological and social functioning expressed as a single number on a 1 to 100 point scale) Low to Normal = 75-100.

Mental illness can be viewed as a collection of symptoms, either behavioral or psychological, which cause an individual distress, disability, or an increased risk of suffering, pain, disability, death, or loss of freedom. Mental illness can be a thinking disorder such as schizophrenia with its characteristic delusions and hallucinations; or a mood disorder with depression; anxiety, panic disorder; a bipolar disorder which may have cycles of depression and mania; behavior disorders; personality disorders; or alcohol and drug dependence disorders.

A mental status examination is an evaluation of a person's current mental functioning, which aids a clinician in arriving at a diagnosis. A typical mental status exam (MSE) covers the following areas:

- Appearance and Behavior: dress, grooming, posture, physical characteristics, facial expression, eye contact, motor activity, cooperation
- Speech: rate, loudness, amount, clarity
- Emotions: mood—depressed, anxious, euphoric, angry
- Thought: Suicidal or homicidal ideation, logic, flow of ideas, content, delusions, preoccupations or obsessions, phobias
- Perception: presence of auditory, visual, tactile, olfactory hallucinations
- Insight and Judgment: orientation to time, place, person, concentration, memory, fund of knowledge, judgment, insight or awareness of mental illness, intelligence

2. *Overview of Substance Abuse versus Substance Dependence*

Substance abuse or substance dependency are terms often heard when a board listens to testimony at a hearing. It is necessary to differentiate between abuse and dependency. *Substance addiction, substance dependence and chemical dependency* refer to an **addiction**, while *substance **abuse** is temporary use of alcohol or other drugs which cause problems in a small part of an individual's life.* Abusers are able to recognize the relationship between their

alcohol and/or drug use, the problems it causes and can stop their abuse with a little help and encouragement.

In dependence, use of the substance becomes progressively worse. A diagnosis of dependency includes meeting the criteria of increased tolerance, withdrawal symptoms, and a pattern of compulsive use. Persons who are dependent continue using substances in spite of increasingly severe consequences in personal and social lives and physical health.

Common symptoms of dependency are: 1) increasing episodes of intoxication; 2) loss of interest in other pursuits; 3) loss of control over usage; 4) repeated remorse over the results of substance use; 5) increased tolerance to the drug (including alcohol); 6) negative reactions to withdrawal from the drug (Best direct evidence of alcoholism is the appearance of withdrawal symptoms one to two days after last drinking alcohol); 7) memory failures as a result of use; 8) serious personal and social consequences resulting from substance use such as problems with relationships, work, or with the law.

Intoxication by itself doesn't indicate dependency. However when episodes of intoxication occur with increasing frequency, involving larger amounts of a substance due to tolerance, resulting in increasingly severe personal and social consequences over an extended period of time--a diagnosis of dependency is almost certain. Other indicators for alcohol dependence are:

- Drinking at or before breakfast
- Drinking non-beverage forms of alcohol (Rubbing alcohol, cologne, etc.)
- Traffic difficulties (DUI, DWI arrests)
- Problems at work related to alcohol use
- Relationship problems related to usage; fighting associated with drinking
- Inability to stop drinking even if the person has wanted to

- Drinking binges
- Black outs (a person has no memory of his behavior or events although during that time he appeared conscious and aware)

3. Overview of "Dual Disorders & Dual Disorder Treatment"

As more and more persons present with multiple problems and illnesses in the commitment process, there is an increasing need to understand the differences between dual disorders, dual disorder treatment and dual enhanced treatment for co-occurring disorders. Understanding the differences between these levels of duality will help the Mental Health Board be able to make appropriate decisions for the least restrictive placement of a person depending upon the severity of the dual issues presented.

A **dual disorder** occurs when an adult has a primary Axis I severe and persistent mental illness (SPMI) diagnosis and a primary Axis I substance dependency diagnosis. It is important to remember that there are only a few mental illnesses that are included within the category of **severe and persistent mental illnesses**: schizophrenia or schizoaffective disorder, bipolar disorder, major depression, and other psychotic disorders. It is also important to know that substance dependency is much more severe and chronic than substance abuse. **Dependency** is a pattern of repeated substance use that results in tolerance, withdrawal, and compulsive substance-taking behavior, where substance abuse does not include these characteristics. The essential feature of dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating continued use despite significant substance-related problems. In combination, these two diagnoses (SPMI/SD) present unique problems for Mental Health Boards in determining the least restrictive treatment placement while ensuring public safety.

There are only a few persons that meet this severe level of dual disorder. The Mental Health Board should carefully determine if the subject in the hearing has this level of severity to be considered dually diagnosed. Dual disorder clients eligible for **dual disorder treatment** will exhibit more unstable or disabling levels of SPMI and dependency. The typical client is disabled to such a degree that specific psychiatric and mental health support, monitoring and accommodation are necessary in order to participate in simultaneous addiction treatment. It is also important to determine if the acute symptoms are stabilized or, if the subject needs further stabilization before being able to benefit from a dual treatment program. The subject must not display symptoms of intoxication and must be stable on psychotropic medication(s) in order to be admitted to a community based dual treatment program. Often a short stay at an acute inpatient program for psychiatric stabilization, and then a move a community based dual disorder residential treatment program provides the most appropriate primary integrated treatment to address both the mental illness and the substance dependency problems simultaneously.

When a person with a mental illness such as schizophrenia acquires a substance dependency, serious consequences result. There can be more severe impairments while using lesser quantities, less frequently. There is a higher risk of non-compliance with mental health treatment, in fact, they are eight times more likely to be non-compliant with medications. Psychiatric symptoms fluctuate more rapidly and are more severe. In addition, there are increased mood swings, more psychiatric re-hospitalizations, violent acting out behavior, suicidal ideation, and suicide attempts. If a person with substance dependency has established an entrenched pattern of chronic use, hallucinations, manic behavior, suicide ideation and delusionary behavior can occur resulting from the habitual use of substances.

A person with a dual disorder requires specific psychiatric and mental health support and monitoring in order to participate in treatment for alcohol and/or drug addiction. Due to the multiple problems, they need an individualized and flexible approach to treatment. The supportive, non-threatening approach is more therapeutic for a dually diagnosed person whereas a confrontive approach would be difficult to tolerate, especially if symptoms of paranoia are present.

4. "Overview of Co-Occurring Disorders & Dual Enhanced Treatment"

An increasingly common diagnosis is when the subject has a primary mental illness and a secondary substance use or abuse disorder, OR a primary substance abuse disorder and a secondary mental illness. These combinations of dual issues are termed C**o-occurring disorders** and are appropriate for **dual enhanced treatment.** Dual enhanced treatment is for persons whose mental illness or substance disorder is less active than the primary diagnosis. Providers(mental health or substance abuse) of these treatment services may elect to "enhance" their primary service to address the client's other relatively stable diagnostic or sub-diagnostic co-occurring disorder. The primary focus of such programs is either mental health OR abuse/dependency treatment rather than dual diagnosis concerns and is not a primary, integrated dual disorder treatment.

Alcohol is the substance most frequently used by persons with mental illnesses, followed by cocaine, marijuana and methamphetamine. About 50% of persons in a psychiatric clinical setting will have a substance disorder. The lifetime prevalence of a substance disorder in persons with schizophrenia is 47%; in those with bipolar disorder, it is 56%; and in those with major depression, it is 27%. Research studies show that 29% of people with an Axis I psychiatric disorder will have a substance abuse disorder at some time in their lives. Persons with mental

illness report similar reasons as the general population for using substances: attempting to improve unpleasant moods such as anxiety and depressions, increasing social interaction, and increasing pleasure by feeling “high”. While mentally ill persons may use substances in order to deal with symptoms, people without mental illness can display psychotic symptoms due to substance use, such as anxiety, panic, mood swings, hallucinations, delusions, amnesia, personality changes, insomnia, and eating-disordered behavior. Both dependence and psychosis feature loss of control of behavior and emotions, and in both instances symptoms respond to treatment.

It is difficult for strictly substance abuse treatment agencies to serve a dually disordered person in their population just as it is difficult for strictly mental health treatment agencies to serve the dually diagnosed person. It is important to note that Nebraska’s Regional Centers provide dual enhanced treatment for co-occurring disorders only. They do not have integrated dual disorder treatment programs nor are they equipped to served the dually diagnosed client. The specific mission of the Regional Centers in Nebraska is to provide acute inpatient and secure residential mental health services. While they have a few licensed alcohol and drug abuse counselors on staff to do dual enhanced programming, treating substance dependency and substance abuse is not a role for the Regional Center. The expertise in substance treatment in Nebraska is in community based programs.